CROMWELL PUBLIC SCHOOLS

CMS/CHS

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

Connecticut State Law requires a written order of an authorized prescriber (i.e., physician, dentist, advanced practice RN, or physician's assistant) and the written authorization of a parent or guardian for a school nurse to administer medication. **Medications are to be brought into the school by parent/guardian or other responsible adult and should be picked up by same at the end of the school year.**

Student's Name: _____ DOB: _____

Authorized Prescriber's Name: _____ Phone#: _____

Authorized Prescriber's Address: _____

Name of Medicine (including generic name): _____ Dose: _____

Route of Administration: _____ Time of Administration: _____

Condition for which drug is being administered during school hours: _____

_____

Is this a controlled drug? ☐ yes ☐ no

Medication shall be administered from: _____ to: _____
(date) (date)

Middle School and High School Only:

Asthma Inhaler Epinephrine Insulin Glucose tablets/gel ☐ may self-carry ☐ may self-administer

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Signature: _____ M.D. DEA #: _____

AUTHORIZATION OF A PARENT OR GUARDIAN CONCERNING THE ADMINISTRATION OF ABOVE MEDICATION BY SCHOOL PERSONNEL

I hereby request that the above medication ordered by an authorized prescriber for my child

_____
(Please print full name of student.)

_____ be administered by school personnel

_____ be administered on field trips

_____ be self-administered

_____ be administered on early dismissal days

I give permission for the exchange of information between the Prescriber and the School Nurse necessary to ensure the safe administration of such medication.

I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 3-month supply of said medication.

I hereby give permission to destroy the medication (or I understand that this medication will be destroyed) if not picked up by the last day of school.

_____ _____ _____
(signature) (phone) (date)

Self Administration:

1. I have conferred with the child's parents/guardians and feel this medication may be self-administered.
2. This student has been appropriately instructed regarding self-medication.

Physician's/Dentist's/APRN's/PA's Signature: _____ Date: _____

Address: _____ Telephone #:_____

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CROMWELL PUBLIC SCHOOLS

AUTHORIZATION FOR THE SELF-ADMINISTRATION OF INHALED ASTHMA MEDICATION

Physician's/Dentist's/Advanced Practice Registered Nurse's/Physician Assistant's Orders

Name of Student: _____ Date: _____

Address: _____ DOB: _____

Condition for which drug is being prescribed: _____

Name of Drug (including generic name): _____

Dose: _____ Frequency: _____

Relevant side effects and management: _____

Medication shall be administered from _____ (date) to _____ (date)

Self Administration:

1. I have conferred with this child's parents/guardians and feel this medication may be self-administered.
2. This student has been appropriately instructed regarding self-medication.

Physician's/Dentist's/APRN's/PA's Name: _____ Telephone #: _____

Address: _____

Physician's/Dentist's/APRN's/PA's Signature: _____ Date: _____

PERMISSION OF PARENT/GUARDIAN FOR SELF-ADMINISTRATION FOR SELF-ADMINISTRATION OF MEDICATION

- I herby request that the above medication, ordered by the physician/dentist/APRN/PA of my child, _____ _____, be administered by my child. I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician/dentist/APRN/PA.
- I understand that I must supply the nurse with back-up medication in the event the medication is lost or misplaced by my child.
- I understand this medication will be destroyed if it is not picked up on the last day of school.
- I give permission for the exchange of information between the prescriber and the School Nurse necessary to ensure the safe administration of such medication.

Name: _____ Date: _____

Signature: _____ Emergency Telephone #: _____

STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION

I understand that I may use my asthma inhaler as prescribed by my doctor. I will not use it in any other way. I will not let any other person use my inhaler. I will go to the school nurse if I do not feel well or the medication does not give me relief after the number of sprays allowed by my doctor. I understand that if I do not follow these rules, I will not be allowed to self-medicate.

Signature of Student: _____ Date: _____

Rev: 2/1/2011

CROMWELL PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medications or in her absence, the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's/dentist's name, and date of original prescription.

PHYSICIAN'S OR DENTIST'S ORDER

Name of Student: _____ Date: _____

Address: _____ DOB: _____

Condition for which drug is being administered during school hours: _____

_____

DRUG: Name (including generic name), dose and method of administration: _____

_____

Time of Administration: _____

Medication shall be administered from _____ (date) to _____ (date)

Relevant side effects to be observed, if any: _____

_____

If there are side effects, plan for management: _____

_____

Is this a controlled drug? ☐ yes ☐ no If yes, DEA number: _____

Physician's or Dentist's Name: _____ (Type or Print) Telephone #: _____

Address: _____

Physician/Dentist Signature: _____ Date: _____

Nurse/Principal/Teacher: _____ Date: _____

AUTHORIZATION BY PARENT/GUARDIAN CONCERNING THE ADMINISTRATION OF ABOVE MEDICATION BY SCHOOL PERSONNEL

I herby request that the above medication, ordered by the physician/dentist of my child, _____ _____, be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 3-month supply of said medication.

I give permission for the exchange of information between the prescriber and the School Nurse necessary to ensure the safe administration of such medication.

NAME: _____ Date: _____

SIGNATURE: _____ Relationship to Child: _____

Address: _____ Telephone #: _____

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